Editorials

A New Clinical Investigation Section

WITH THIS ISSUE the *WJM* inaugurates a Clinical Investigation Section in affiliation with five western societies that are interested in clinical research. This section should be of particular value to those readers who are students or residents, or themselves do research. However, it is expected that each article will contain something of clinical or potential clinical interest and so should be worth the attention of virtually all of our readers. We look forward to the development of this section under the leadership of R. Paul Robertson, MD.

—THE EDITORS

Some Elements of Quality

IN THESE TROUBLED TIMES when there is so much emphasis on trying to make health care less costly or, as some might say, cheaper, physicians and the medical profession have quite properly taken the stand that while cost control is a worthy goal to be vigorously pursued, this must not be at the expense of the quality of care that is available to our patients and to the public. While it is clear the cost and quality of patient care have some relationship, it is also a fact that the costs are comparatively easy to measure whereas it has not been so easy to define or measure the quality. For this reason it is often difficult to show in what ways quality is or is not sacrificed when costs are cut. There is a pressing need to know more precisely what we are talking about when we speak of quality in patient care.

It is generally conceded that the Japanese automobile makers have found ways to make automobiles of better quality at less cost than have American manufacturers. Given the many reasons for their lower costs (some of which are obvious and some probably not so obvious), one may then ask how they make sure of the quality of their product. It has been said that the Japanese automobile makers have identified four elements that should be present in the manufacturing process to assure quality. These are (1) standards, (2) performance, (3) accountability and (4) something that might be called esprit de corps or a sense of group pride in the quality of the product. Apocryphal as this may be, perhaps something can be learned from it about how to tell better whether quality is or is not present in patient care as this is rendered under one or another economic arrangement.

Standards. We have already in place a relatively sophisticated system of standards for professional education (accreditation and certification), for drugs and equipment (FDA) and for hospitals and health care institutions (JCAH and licensure). We are beginning to develop generally accepted standards for the therapy of some conditions such as hypertension and diabetes mellitus. As the scientific data bases improve it may be expected that there will be more accepted standards for the treatment of more conditions. So it is indeed true that the medical profession has its standards and that they are high. It is only to be hoped that they will not be too seriously eroded by antitrust or other shortsighted actions by governments, courts or anyone else.

Performance. Over the years the medical profession has been increasingly concerned about performance in patient care. It began with tissue committees in hospitals which sought to relate surgical procedures to outcomes. More recently other forms of peer review have become commonplace, especially in hospital settings. The harsh realities of successful malpractice actions, both justified and not so justified, have focused greater attention on practice performance. So far it has been difficult to apply peer review to practice performance in physicians' offices outside of a hospital, clinic or a group practice. While the medical profession has been a leader among the professions in developing peer review of practice performance, its monitoring of professional performance certainly does not match the monitoring of the performance of the workers that is done to assure quality in a Japanese automobile. We are probably only at the beginning of what needs to be done in peer review of practice performance by physicians and other health professionals if we are to be able to measure and assure the quality of care rendered in the different economic arrangements that are coming into being.

Accountability. Accountability is a step beyond actual performance. It requires data to support what is done. To the extent that medical practice is an art this accountability is difficult; to the extent that it is a science data can be developed so as to make it accountable. The science of accountability in medical practice and patient care is in its infancy, yet it seems essential that this be developed if we are to know whether or not there is quality in patient care rendered in different settings.

Esprit. Esprit is something more readily sensed than measured. One senses that it is now usually present in good measure among health care providers, in health care institutions and in the health care teams that give care to patients. But one also senses that this esprit may be fragile and become threatened in circumstances where harsh competition displaces an atmosphere of cooperation and close collaboration, or when unwanted or poorly understood policy decisions are made by far-off governments or some sort of absentee corporate landlords. Although difficult to measure, esprit or pride in workmanship among physicians and other health care providers is an essential element in the quality of patient care.

At this moment the powers that be in government and elsewhere are giving lip service to maintaining quality